FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 00020842

Facility Name: HALSTED TERRACE NURSING CENTER, INC.

Address: 10935 S. Halsted (Number) Chicago (City) 60628 (Zip Code)

County: Cook

Telephone Number: (773) 928-2000 **Fax #** (773) 928-9154

IDPA ID Number: 36-2877302

Date of Initial License for Current Owners: 05/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	Noshir Daruwalla, CPA
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	300	Skilled (SNF)	300	109,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	300	TOTALS	300	109,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	62,398	2,134	3,171	67,703	8
9	SNF/PED					9
10	ICF	29,233	1,439	630	31,302	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	91,631	3,573	3,801	99,005	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.17%

D. How many bed-hold days during this year were paid by Public Aid? 1,997 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 3,137

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	269,114	106,150	11,452	386,716		386,716	4,539	391,255			1
2	Food Purchase		378,789		378,789	(28,072)	350,717	(136)	350,580			2
3	Housekeeping	300,446	59,937		360,383		360,383	14,842	375,225			3
4	Laundry	74,812	39,893		114,705		114,705		114,705			4
5	Heat and Other Utilities			174,055	174,055		174,055	4,752	178,807			5
6	Maintenance	70,547	15,422	96,884	182,853		182,853	(6,988)	175,865			6
7	Other (specify):*											7
8	**TOTAL General Services**	714,919	600,191	282,391	1,597,501	(28,072)	1,569,429	17,009	1,586,437			8
	B. Health Care and Programs											
9	Medical Director			30,600	30,600		30,600		30,600			9
10	Nursing and Medical Records	2,980,379	263,925	12,577	3,256,881		3,256,881	(252)	3,256,629			10
10a	Therapy	130,386		14,413	144,799		144,799		144,799			10a
11	Activities	201,628	14,476	1,984	218,088		218,088		218,088			11
12	Social Services	93,412		3,996	97,408		97,408		97,408			12
13	Nurse Aide Training											13
14	Program Transportation			2,100	2,100		2,100		2,100			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,405,805	278,401	65,670	3,749,876		3,749,876	(252)	3,749,624			16
	C. General Administration											
17	Administrative	232,747		580,200	812,947		812,947	(427,619)	385,328			17
18	Directors Fees											18
19	Professional Services			846,522	846,522		846,522	(497,824)	348,698			19
20	Dues, Fees, Subscriptions & Promotions			110,660	110,660		110,660	(27,875)	82,785			20
21	Clerical & General Office Expenses	262,730	10,689	306,676	580,095		580,095	29,030	609,125			21
22	Employee Benefits & Payroll Taxes			697,700	697,700	28,072	725,772		725,772			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,360	2,360		2,360	1,050	3,410			24
25	Other Admin. Staff Transportation			1,856	1,856		1,856		1,856			25
26	Insurance-Prop.Liab.Malpractice			131,513	131,513		131,513	894	132,407			26
27	Other (specify):*							53,939	53,939			27
28	**TOTAL General Administration**	495,477	10,689	2,677,487	3,183,653	28,072	3,211,725	(868,405)	2,343,320			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,616,201	889,281	3,025,548	8,531,030		8,531,030	(851,648)	7,679,382			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

HALSTED TERRACE NURSING CENTER, INC.
00020842
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	28,072	
2	FOOD		28,072

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. #00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			165,733	165,733		165,733	487,967	653,700			30
31	Amortization of Pre-Op. & Org.							10,405	10,405			31
32	Interest			247,463	247,463		247,463	538,750	786,213			32
33	Real Estate Taxes							290,307	290,307			33
34	Rent-Facility & Grounds			1,316,236	1,316,236		1,316,236	(1,314,000)	2,236			34
35	Rent-Equipment & Vehicles			30,911	30,911		30,911	(3,317)	27,594			35
36	Other (specify):*							41,659	41,659			36
37	**TOTAL Ownership**			1,760,343	1,760,343		1,760,343	51,771	1,812,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,592	188,881	319,473		319,473		319,473			39
40	Barber and Beauty Shops			929	929		929		929			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			164,700	164,700		164,700		164,700			42
43	Other (specify):*	49,679			49,679		49,679	(49,679)				43
44	**TOTAL Special Cost Centers**	49,679	130,592	354,510	534,781		534,781	(49,679)	485,102			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,665,880	1,019,873	5,140,401	10,826,154		10,826,154	(849,556)	9,976,598			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	251,400	30		9
10	Interest and Other Investment Income	(32,359)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(136)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,558)	21		18
19	Entertainment				19
20	Contributions	(15,857)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,995)	21		24
25	Fund Raising, Advertising and Promotional	(9,225)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(300)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,763)	20		28
29	Other-Attach Schedule	(378,674)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (268,467)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(581,089)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (581,089)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (849,556)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HALSTED TERRACE NURSING CENTER, INC.

ID# 00020842

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Seminar - Out of State Travel	(491)	24	2
3	Political Contributions - ICLTC	(557)	20	3
4	Veterans Expense	(252)	10	4
5	Bank Charges	(861)	21	5
6	Theft & Damage Loss	(500)	21	6
7	B. Cohen - Management Fees	(95,000)	17	7
8	Board of Elections	(200)	21	8
9	J. Miller-Johnson - Auto Reimbursement	(2,990)	17	9
10	C. Miree - Auto Reimbursement	(1,779)	21	10
11	R. Kenard - Auto Reimbursement	(854)	17	11
12	B. Cohen - Accounting Fees	(42,000)	19	12
13	Prior Year Legal Fees	(1,886)	19	13
14	Public Relations	(136,592)	21	14
15	Auto Lease - Not Allowed	(6,745)	35	15
16	Excess Cost - Lexus	(1,402)	30	16
17	Capitalized Repair & Maintenance	(11,200)	6	17
18	Marketing Salary	(49,679)	43	18
19				19
20	Halsted Associates - State Replacement Tax	(3,990)	21	20
21	Halsted Associates - Professional Fees	(12,652)	19	21
22	Missing Legal Invoice	(5,000)	19	22
23	Non-allowable Legal Fees	(4,044)	19	23
24				24
25				25
26				26
27				27
28				28
29				29
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32				32
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86				86
87				87
88				88
89				89
90	**Total**	(378,674)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				4,539								4,539	1
2	Food Purchase	(136)											(136)	2
3	Housekeeping				14,842								14,842	3
4	Laundry													4
5	Heat and Other Utilities				4,752								4,752	5
6	Maintenance	(11,200)			4,212								(6,988)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(11,336)			28,345								17,009	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(252)											(252)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(252)											(252)	16
	C. General Administration													
17	Administrative	(98,844)		28,169		(174,629)	(182,315)						(427,619)	17
18	Directors Fees													18
19	Professional Services	(65,582)	12,652	(61,630)	(384,556)		1,292						(497,824)	19
20	Fees, Subscriptions & Promotions	(31,402)		1,182	2,345								(27,875)	20
21	Clerical & General Office Expenses	(221,775)	4,440	8,399	233,514	172	4,280						29,030	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(491)		46	1,495								1,050	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				894								894	26
27	Other (specify):*			4,898	43,589	236	5,216						53,939	27
28	**TOTAL General Administration**	(418,094)	17,092	(18,936)	(102,719)	(174,221)	(171,527)						(868,405)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(429,682)	17,092	(18,936)	(74,374)	(174,221)	(171,527)						(851,648)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	249,998	208,205		29,764								487,967	30
31	Amortization of Pre-Op. & Org.		10,129		276								10,405	31
32	Interest	(32,359)	549,733		21,376								538,750	32
33	Real Estate Taxes		281,673		8,634								290,307	33
34	Rent-Facility & Grounds		(1,314,000)										(1,314,000)	34
35	Rent-Equipment & Vehicles	(6,745)			3,428								(3,317)	35
36	Other (specify):*		41,659										41,659	36
37	**TOTAL Ownership**	210,894	(222,601)		63,478								51,771	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,679)											(49,679)	43
44	**TOTAL Special Cost Centers**	(49,679)											(49,679)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(268,467)	(205,509)	(18,936)	(10,896)	(174,221)	(171,527)						(849,556)	45

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Halsted Associates		Bldg. Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,314,000	Halsted Associates		$	$ (1,314,000)	1
2	V	32	Interest Income	88,880	Halsted Associates			(88,880)	2
3	V	21	Office Expenses		Halsted Associates		450	450	3
4	V	19	Professional Fees		Halsted Associates		12,652	12,652	4
5	V	31	Amortization		Halsted Associates		10,129	10,129	5
6	V	33	Real Estate Taxes		Halsted Associates		281,673	281,673	6
7	V	32	Interest Expense		Halsted Associates		638,613	638,613	7
8	V	36	Insurance		Halsted Associates		41,659	41,659	8
9	V	30	Depreciation		Halsted Associates		208,205	208,205	9
10	V	21	State Replacement Tax		Halsted Associates		3,990	3,990	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,402,880			$ 1,197,371	$ * (205,509)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 28,169	$ 28,169	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	681	681	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	1,182	1,182	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	8,399	8,399	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	46	46	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	4,898	4,898	20
21	V								21
22	V								22
23	V								23
24	V	19	MANAGEMENT FEES	62,311	CAREPATH HEALTH NETWORK	100.00%		(62,311)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 62,311			$ 43,375	$ * (18,936)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	ITEX COMPANY/A.K. CARE	100.00%	$ 4,539	$ 4,539	15
16	V	3	HOUSEKEEPING		ITEX COMPANY/A.K. CARE	100.00%	14,842	14,842	16
17	V	5	UTILITIES		ITEX COMPANY/A.K. CARE	100.00%	4,752	4,752	17
18	V	6	REPAIRS AND MAINT.		ITEX COMPANY/A.K. CARE	100.00%	4,212	4,212	18
19	V	19	PROFESSIONAL FEES		ITEX COMPANY/A.K. CARE	100.00%	7,844	7,844	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX COMPANY/A.K. CARE	100.00%	2,345	2,345	20
21	V	21	CLERICAL AND GENERAL		ITEX COMPANY/A.K. CARE	100.00%	34,634	34,634	21
22	V	24	EDUCATION/SEMINARS		ITEX COMPANY/A.K. CARE	100.00%	1,495	1,495	22
23	V	26	INSURANCE		ITEX COMPANY/A.K. CARE	100.00%	894	894	23
24	V	27	EMPLOYEE BENEFITS		ITEX COMPANY/A.K. CARE	100.00%	625	625	24
25	V	30	DEPRECIATION		ITEX COMPANY/A.K. CARE	100.00%	29,764	29,764	25
26	V	31	AMORTIZATION		ITEX COMPANY/A.K. CARE	100.00%	276	276	26
27	V	32	INTEREST		ITEX COMPANY/A.K. CARE	100.00%	21,376	21,376	27
28	V	33	REAL ESTATE TAXES		ITEX COMPANY/A.K. CARE	100.00%	8,634	8,634	28
29	V	35	EQUIPMENT RENTAL		ITEX COMPANY/A.K. CARE	100.00%	3,428	3,428	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX COMPANY/A.K. CARE	100.00%	198,880	198,880	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX COMPANY/A.K. CARE	100.00%	42,964	42,964	33
34	V								34
35	V	19	BOOKKEEPING SERVICES	392,400	ITEX COMPANY/A.K. CARE	100.00%		(392,400)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 392,400			$ 381,504	$ * (10,896)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 5,371	$ 5,371	15
16	V	21	OFFICE		JLR MANAGEMENT CORP.	100.00%	172	172	16
17	V	27	PAYROLL TAXES		JLR MANAGEMENT CORP.	100.00%	236	236	17
18	V	0							18
19	V	0							19
20	V	0							20
21	V	17	MARVIN NEEDLE-CONS. FEES						21
22	V	0							22
23	V	0							23
24	V	17	MARK BERGER-CONS. FEES						24
25	V	21	SECRETARIAL						25
26	V	0							26
27	V	0							27
28	V	0							28
29	V	17	MANAGEMENT FEES	180,000	JLR MANAGEMENT CORP.	100.00%		(180,000)	29
30	V	0							30
31	V	0							31
32	V	0							32
33	V	0							33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 180,000			$ 5,779	$ * (174,221)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	BERNIE HOLLANDER-SAL.	$	SHAYMARK MANAGEMENT CORP.	100.00%	$ 117,685	$ 117,685	15
16	V		19	PROFESSIONAL FEES		SHAYMARK MANAGEMENT CORP.	100.00%	1,292	1,292	16
17	V		21	OFFICE		SHAYMARK MANAGEMENT CORP.	100.00%	4,280	4,280	17
18	V		27	PAYROLL TAXES		SHAYMARK MANAGEMENT CORP.	100.00%	5,216	5,216	18
19	V									19
20	V									20
21	V									21
22	V		17	MANAGEMENT FEES	300,000	SHAYMARK MANAGEMENT CORP.	100.00%		(300,000)	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 300,000			$ 128,473	$ * (171,527)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HALSTED TERRACE NURSING CENTEI # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jack Rajchenbach	Vice President	Management	10.00%	See Attached	2	3.08%	Alloc. Salary	$ 5,370	17-7	1
2	Bernard Hollander	President	Admin./Mgmt	83.33%	See Attached	31	47.69%	Alloc. Salary	110,763	17-7	2
3	Mark Hollander	Relative	Administrative		See Attached	25	41.67	Salary	147,730	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 263,863		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	62,311	$ 28,169	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		62,311	681	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		62,311	1,182	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	62,311	8,399	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		62,311	46	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		62,311	4,898	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 43,375	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX COMPANY/A.K. CARE
Street Address: 6633 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	463,722	5	$ 19,169	$	109,800	$ 4,539	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	463,722	5	62,684		109,800	14,842	2
3	5	UTILITIES	AVAILABLE BED DAYS	463,722	5	20,070		109,800	4,752	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	463,722	5	17,788		109,800	4,212	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	463,722	5	33,128		109,800	7,844	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	463,722	5	9,905		109,800	2,345	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	463,722	5	146,272		109,800	34,634	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	463,722	5	6,314		109,800	1,495	8
9	26	INSURANCE	AVAILABLE BED DAYS	463,722	5	3,777		109,800	894	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	463,722	5	2,641		109,800	625	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	463,722	5	125,704		109,800	29,764	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	463,722	5	1,164		109,800	276	12
13	32	INTEREST	AVAILABLE BED DAYS	463,722	5	90,279		109,800	21,376	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	463,722	5	36,464		109,800	8,634	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	463,722	5	14,476		109,800	3,428	15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		5	735,869	735,869		198,880	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	158,969			42,964	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,673	$ 735,869		$ 381,504	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	$ 163,800	$ 163,800	2	$ 5,371	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		2	172	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,210		2	236	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	46,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	40	2	15,000				10
11	21	SECRETARIAL	AVG. HOURS WORKED	40	2	5,000				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 242,541	$ 163,800		$ 5,779	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHAYMARK MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	BERNIE HOLLANDER-SAL.	AVG. HOURS WORKED	48	4	$ 182,222	$ 182,222	31	$ 117,685	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	48	4	2,000		31	1,292	2
3	21	OFFICE	AVG. HOURS WORKED	48	4	6,626	6,626	31	4,280	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	48	4	8,076		31	5,216	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 198,924	$ 188,849		$ 128,473	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HALSTED TERRACE NURSING CENTER # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Halsted Associates	X		Mortgage	$58,973.00	2/1/94	$ 8,746,500	$ 8,294,129	3/1/2029	7.5%	$ 627,901	1
2	Mid-America Elevator Co.		X	Elevator upgrade & maint.	$2,977.87	5/99	148,200	102,818	04/03/04	7.9%	10,145	2
3	Hill-Rom		X	Purchase Beds				5,857			664	3
4												4
5												5
	Working Capital											
6	American National Bank		X	Line of Credit			2,000,000	1,375,000		Varies	57,377	6
7	Bernard Hollander	X		Line of Credit				983,524			82,443	7
8	Intercompany	X									82,870	8
9	TOTAL Facility Related				$61,950.87		$ 10,894,700	$ 10,761,328			$ 861,400	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(75,187)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (75,187)	14
15	TOTALS (line 9+line14)						$ 10,894,700	$ 10,761,328			$ 786,213	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, I# 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Shareholder Loan	X					$	$			$ 900	1
2	Illinois Dept. of Revenue		X								2	2
3	Interest Income										(32,359)	3
4	Itex	X		Allocation - Interest Expense							21,376	4
5	Medicare Settlement		X								171	5
6	Halsted Associates	X		Note Payable							10,712	6
7	Halsted Associates	X		Interest Income							(88,880)	7
8	Therapeutic Systems		X	Interest on unpaid bills							12,891	8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (75,187)	21

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	299,847	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	292,302	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,545)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	297,851	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	290,306	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	231,617	8
	1996	237,211	9
	1997	280,557	10
	1998	285,569	11
	1999	283,668	12

Accrual = 1998 Actual Tax X 1.05%
283668 * 1.05 = 297,851
Itex Allocation = 8634

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,068 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 284,441
2. Number of Years Over Which it is Being Amortized: 25
3. Current Period Amortization: 10,405
4. Dates Incurred: 1995

Nature of Costs: $10129 = Loan Costs;$276 Allocated from Itex
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 855,000	1
2					2
3	TOTALS			$ 855,000	3

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 7,334,294	$ 205,099	35	$ 366,715	$ 161,616	$ 2,536,445	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	750		20			12,197	9
10	Various			1979	12,807	201	20	201		12,071	10
11	Various			1980	35,915		20			37,892	11
12	Various			1981	13,910		20			13,910	12
13	Various			1982	8,814		20			8,814	13
14	Various			1983	12,936		20			12,936	14
15	Various			1984	20,560		20			20,560	15
16	Various			1985	18,883	96	20	96		18,541	16
17	Various			1986	2,456	103	20	103		11,558	17
18	Various			1987	4,000	127	20	127		10,714	18
19	Various			1988	82,596	2,621	20	2,621		60,286	19
20	Various			1989	1,225	39	20	39		444	20
21	Various			1990	91,597	2,842	20	2,842		33,681	21
22	Various			1993	53,620	1,493	20	2,728	1,235	23,493	22
23	Various			1995	137,949	5,526	20	7,063	1,537	37,880	23
24											24
25	PAGE 12-1 REP TOTALS				1,257,176	16,170		54,950	38,780	368,332	25
26											26
27											27
28											28
29	PAGE 12G TOTALS				24,950			840	840	840	29
30	PAGE 12F TOTALS				104,850	2,936		5,177	2,241	7,768	30
31	PAGE 12E TOTALS				180,435	7,773		9,563	1,790	14,955	31
32	PAGE 12D TOTALS				100,220	3,541		5,078	1,537	12,278	32
33	PAGE 12C TOTALS				75,577	2,367		3,862	1,495	14,125	33
34	PAGE 12B TOTALS				367,093	12,250		19,607	7,357	97,193	34
35	PAGE 12A TOTALS				165,983	4,147		8,298	4,151	37,830	35
36	TOTAL (lines 4 thru 35)				$ 10,108,596	$ 267,331		$ 489,910	$ 222,579	$ 3,404,743	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL COVERING			1996	1,645		20	82	82	369	9
10	DRYWALL			1996	5,906	151	20	295	144	1,426	10
11	METAL FRAME			1996	2,410	62	20	121	59	585	11
12	CERAMIC TILES			1996	205	5	20	10	5	44	12
13	FABRICATE WINDOW SIL			1996	1,257	32	20	63	31	299	13
14	DINING ROOM FLOOR			1996	10,265	263	20	513	250	2,394	14
15	PRESSURE RELEIF VALV			1996	1,073	28	20	54	26	257	15
16	CONCRETE RAMP			1996	1,800	46	20	90	44	413	16
17	PATIO			1996	440	11	20	22	11	103	17
18	IRON-FENCE			1996	32,700	838	20	1,635	797	7,630	18
19	GROUND TUBING			1996	2,141	55	20	107	52	446	19
20	CHILLER			1996	31,368	804	20	1,568	764	7,187	20
21	ITALIAN TILES			1996	910	23	20	46	23	226	21
22	FLOORING			1996	4,961	127	20	248	121	1,137	22
23	CHILLED WATER COOLIN			1996	5,082	130	20	254	124	1,143	23
24	ROOF DRAIN			1996	4,365	112	20	218	106	945	24
25	FLOORING-TV AREA			1996	8,000	205	20	400	195	1,800	25
26	FISSURED 5/8X2X4			1996	588	15	20	29	14	128	26
27	TOILETS			1996	1,685	43	20	84	41	364	27
28	FLOORING			1996	325	8	20	16	8	77	28
29	CERAMIC TILES			1996	11,250	288	20	563	275	2,487	29
30	DRYWALL			1996	69	2	20	3	1	15	30
31	FLOORING			1996	25,925	665	20	1,296	631	5,616	31
32	DOORWAY			1996	2,441	63	20	122	59	519	32
33	FLOORING			1996	1,950	50	20	98	48	408	33
34	P.T.ROOM-DRAIN			1996	4,700	121	20	235	114	1,077	34
35	TELEPHONE			1996	2,522		20	126	126	735	35
36	TOTAL (lines 4 thru 35)				$ 165,983	$ 4,147		$ 8,298	$ 4,151	$ 37,830	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CEILINGS			1996	2,570	66	20	129	63	559	9
10	DOORS			1996	2,950	76	20	148	72	629	10
11	WALL COVERING			1996	5,305	611	20	265	(346)	1,414	11
12	PATIO			1996	10,760	276	20	538	262	2,556	12
13	LUMBER			1996	2,426	62	20	121	59	514	13
14	S & G CONSTRUCTION			1996	229,387	6,523	20	12,719	6,196	63,595	14
15	CEILING			1996	1,300	33	20	65	32	265	15
16	DOORS			1996	2,426	62	20	121	59	514	16
17	LIGHTING CIRCUITS			1996	1,550	40	20	78	38	358	17
18	LANDSCAPING			1996	30,044	2,081	20	1,502	(579)	6,634	18
19	LAWN SPRINKLER			1996	5,890	408	20	295	(113)	1,328	19
20	SHRUBS			1996	7,754	537	20	388	(149)	1,617	20
21	TILES			1996	11,870	304	20	594	290	2,970	21
22	LUMBER			1996	392	10	20	20	10	82	22
23	FIXTURE			1996	1,377	35	20	69	34	293	23
24	FLOURESCENT FIXTURE			1996	702	81	20	35	(46)	187	24
25	RECESSED LIGHT FIX.			1996	1,390		20	70	70	315	25
26	WALLCOVERING			1996	452		20	23	23	100	26
27	FIXTURES			1996	1,010	26	20	51	25	213	27
28	RECESSED LIGHT FIX.			1996	594		20	30	30	135	28
29	FIRE ALARM			1996	37,327		20	1,866	1,866	10,575	29
30	WALL COVERING			1996	257	29	20	13	(16)	56	30
31	WALLCOVERING			1996	2,043	235	20	102	(133)	442	31
32	DRAPERY			1996	5,498	633	20	275	(358)	1,421	32
33	WALL COVERING			1996	249	29	20	12	(17)	56	33
34	WALL COVERING			1996	767		20	38	38	178	34
35	WALL COVERING			1996	803	93	20	40	(53)	187	35
36	TOTAL (lines 4 thru 35)				$ 367,093	$ 12,250		$ 19,607	$ 7,357	$ 97,193	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL COVERING			1996	1,110	128	20	56	(72)	270	9
10	WALL COVERING			1996	1,342	155	20	67	(88)	302	10
11	WALL COVERING			1996	2,579	297	20	129	(168)	667	11
12	FLOOR			1997	995	26	20	50	24	192	12
13	AWNING			1997	4,393	113	20	220	107	715	13
14	FLOOR TILES			1997	10,400	267	20	520	253	1,863	14
15	PANIC DEVICES			1997	4,050	104	20	203	99	812	15
16	DOORS			1997	1,600	184	20	160	(24)	547	16
17	ALUMINUM DOOR			1997	3,595	92	20	180	88	675	17
18	ARMSTRONG-FLOOR			1997	11,550	296	20	578	282	1,927	18
19	ARMSTRONG-BATHROOM			1997	1,885	48	20	94	46	321	19
20	ULHM DOORS			1997	1,792		20	90	90	345	20
21	DRAPES			1997	1,850	213	20	93	(120)	302	21
22	INSTALL CABLE			1997	7,066	181	20	353	172	1,147	22
23	CARRIER AIR COND			1997	2,432		20	122	122	427	23
24	FLOOR			1997	708		20	35	35	128	24
25	PLUMBING			1997	950		20	48	48	192	25
26	SPRINKLER SYS.			1997	1,108		20	55	55	220	26
27	SPRINKLER SYS			1997	1,041		20	52	52	191	27
28	PARKING LOT			1997	860		20	43	43	143	28
29	DRAPES			1997	614	71	20	31	(40)	124	29
30	ALARM PANEL			1997	1,030		20	52	52	204	30
31	7000 BTU AIR COND			1997	2,763		20	138	138	483	31
32	TOILETS			1997	698		20	35	35	140	32
33	SAFETY RAILS			1997	701		20	35	35	140	33
34	ELECTRICAL SYS			1997	965		20	48	48	148	34
35	ARMSTRONG FLOOR			1997	7,500	192	20	375	183	1,500	35
36	TOTAL (lines 4 thru 35)				$ 75,577	$ 2,367		$ 3,862	$ 1,495	$ 14,125	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DISABLE ACCESS			1997	3,680	94	20	184	90	644	9
10	STORE W/DOOR			1997	2,322	60	20	116	56	464	10
11	FIRE DAMPER			1998	10,365	266	20	518	252	1,036	11
12	FENCE			1998	2,962	253	20	148	(105)	395	12
13	FENCE			1998	3,870	331	20	194	(137)	566	13
14	MORTON FLOORS			1998	5,415	139	20	271	132	745	14
15	RADIANT HEATER			1998	2,250	58	20	113	55	301	15
16	FLOOR			1998	2,950	76	20	148	72	345	16
17	ELEVATOR			1998	3,480	89	20	174	85	464	17
18	AIR CONDITIONERS			1998	4,575		20	229	229	458	18
19	LOCKS			1998	13,366	343	20	668	325	2,060	19
20	METAL DOOR FRAMES			1998	4,603	118	20	230	112	498	20
21	FENCE			1998	1,088	28	20	54	26	149	21
22	AWNING			1998	1,365	35	20	68	33	159	22
23	OUTLETS & FIXTURES			1998	592		20	30	30	63	23
24	LOCKS			1998	9,001	231	20	450	219	975	24
25	ELEVATOR PADS			1998	1,360	35	20	68	33	164	25
26	ROOF			1998	4,400	376	20	220	(156)	550	26
27	PREFINISHED FRAMES			1998	1,385		20	69	69	178	27
28	KICKPLATES/HANDRAILS			1998	1,386		20	69	69	167	28
29	ROOF REPAIRS			1998	3,075		20	154	154	449	29
30	BASEBOARD			1999	1,055	27	20	53	26	84	30
31	DOORS			1999	9,021	231	20	451	220	789	31
32	TILE			1999	1,275	33	20	64	31	107	32
33	SINKS & TOILETS			1999	1,275	33	20	64	31	96	33
34	LANDSCAPING			1999	2,790	265	20	140	(125)	175	34
35	WALL LIFHTS & RECEPT			1999	1,314	420	20	131	(289)	197	35
36	TOTAL (lines 4 thru 35)				$ 100,220	$ 3,541		$ 5,078	$ 1,537	$ 12,278	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	COVE BASE STOOPS			1999	956	25	20	48	23	68	9
10	CARPET			1999	10,811	3,460	20	1,081	(2,379)	1,531	10
11	SPRINKLER HEAD			1999	550	14	20	28	14	42	11
12	FENCE			1999	1,100	105	20	55	(50)	87	12
13	ELECTRICAL FIXTURE			1999	563		20	28	28	56	13
14	CLOSETS			1999	692	18	20	35	17	55	14
15	ELEVATOR			1999	114,600	2,938	20	5,730	2,792	9,073	15
16	BASEBOARDS			1999	1,631	42	20	82	40	96	16
17	TILE			1999	1,220	31	20	61	30	97	17
18	FIRE DAMPER RELAY			1999	1,109	28	20	55	27	110	18
19	FIRE DAMPERS			1999	510	13	20	26	13	52	19
20	DOORS			1999	343	9	20	17	8	34	20
21	DOORS			1999	10,423	267	20	521	254	1,042	21
22	SMOKE DAMPER AND DUC			1999	1,120	29	20	56	27	103	22
23	DOOR FRAMES			1999	5,258	135	20	263	128	460	23
24	FIRE DAMPER&DUCT WOR			1999	2,025	52	20	101	49	160	24
25	AWNINGS			1999	3,943	101	20	197	96	312	25
26	FIRE DAMPERS			1999	1,188	30	20	59	29	108	26
27	WINDOW TREATMENTS			1999	1,864		20	93	93	186	27
28	SPRINKLER HEADS			1999	850	22	20	43	21	65	28
29	BASEBOARDS			1999	1,078	28	20	54	26	63	29
30	STEAMER			1999	705		20	35	35	50	30
31	CEILING TILE			1999	8,496	218	20	425	207	531	31
32	FIRE ALARM & RELAYS			1999	1,263	32	20	63	31	68	32
33	LOCKS & KEYS			1999	6,858	176	20	343	167	400	33
34	KITCHEN EXHAUST			1999	755		20	38	38	67	34
35	HOSES			1999	524		20	26	26	39	35
36	TOTAL (lines 4 thru 35)				$ 180,435	$ 7,773		$ 9,563	$ 1,790	$ 14,955	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLCOVERING			1999	2,473		20	124	124	248	9
10	FLOURESCENT FIXTURES			1999	2,756		20	138	138	276	10
11	CARPET			1999	1,605		20	80	80	160	11
12	FLOURESCENT FIXTURES			1999	2,253		20	113	113	226	12
13	WALLCOVERING			1999	600		20	30	30	60	13
14	DOORS			1999	27,168	697	20	1,358	661	1,584	14
15	CLOSETS			1999	1,729	44	20	86	42	136	15
16	NURSING STATION			1999	6,700		20	335	335	670	16
17	LOCKS			1999	8,033	244	20	477	233	795	17
18	COOLER			1999	602		20	30	30	45	18
19	DOOR FRAMES			1999	2,171	56	20	109	53	127	19
20	WIRING			1999	1,344		20	67	67	78	20
21	WALLCOVERINGS			1999	20,218		20	1,011	1,011	2,022	21
22	CHILLERS			1999	993		20	50	50	75	22
23	WALLCOVERINGS			1999	636		20	32	32	64	23
24	SMOKE DETECTOR			1999	726		20	36	36	66	24
25	DRAIN LINES			1999	1,400		20	70	70	105	25
26	HEAT EXCHANGER			2000	1,942		20	97	97	97	26
27	TILE			2000	760		20	29	29	29	27
28	MODEM HOOKUP			2000	1,617	231	20	135	(96)	135	28
29	WALLCOVERING			2000	1,352		20	57	57	57	29
30	TMX AND LMX CARDS			2000	1,519	1,519	20	152	(1,367)	152	30
31	FLOURESCENT FIXTURES			2000	3,307		20	151	151	151	31
32	FLOURESCENT FIXTURES			2000	2,911		20	134	134	134	32
33	ROOF REPAIRS			2000	7,143	145	20	153	8	153	33
34	FLORESCENT FIXTURES			2000	2,014		20	101	101	101	34
35	SPRINKLER HEAD			2000	878		20	22	22	22	35
36	TOTAL (lines 4 thru 35)				$ 104,850	$ 2,936		$ 5,177	$ 2,241	$ 7,768	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOURESCENT FIXTURES			2000	1,488		20	74	74	74	9
10	A/C REPAIRS			2000	12,021		20	250	250	250	10
11	FLOURESCENT FIXTURES			2000	494		20	4	4	4	11
12	ELEVATOR REPAIR			2000	1,393		20	70	70	70	12
13	FREEZER			2000	571		20	29	29	29	13
14	SPRINKLER SYSTEM			2000	1,000		20	50	50	50	14
15	WALLCOVERING			2000	1,415		20	59	59	59	15
16	SWITCHES			2000	525		20	26	26	26	16
17	PUMP			2000	521		20	26	26	26	17
18	BOILER			2000	1,150		20	58	58	58	18
19	SPRINKLER RINGS			2000	1,316		20	66	66	66	19
20	EXTERIOR INSULATION			2000	511		20	26	26	26	20
21	TILE			2000	1,981		20	74	74	74	21
22	SPRINKLER RINGS			2000	564		20	28	28	28	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 24,950	$		$ 840	$ 840	$ 840	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Alloc. Itex	$ 162,980	$ 4,179	35	$ 4,657	$ 478	$ 35,312	4
5			1992	Alloc. Itex	216,827	5,560	35	6,195	635	46,979	5
6											6
7											7
8											8
	Improvement Type**										
9	Itex - Various			1993	47,791	1,675	20	2,390	715	18,413	9
10	Itex - Various			1994	25,669	1,057	20	1,283	226	8,062	10
11	Itex - Various			1995	4,375	361	20	219	(142)	1,137	11
12	Itex - Various			1996	248	22	20	12	(10)	62	12
13	Itex - Various			1997	7,382	189	20	369	180	1,291	13
14	Itex - Various			1999	819	21	20	41	20	82	14
15	Halsted Associates - Various			1994	791,085	3,106	20	39,784	36,678	256,994	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,257,176	$ 16,170		$ 54,950	$ 38,780	$ 368,332	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,593,359	$ 103,959	$ 159,054	$ 55,095		$ 843,009	37
38	Current Year Purchases	37,554	23,410	2,731	(20,679)		(15,750)	38
39	Fully Depreciated Assets	561,064	7,227	230	(6,997)		561,064	39
40								40
41	TOTALS	$ 2,191,977	$ 134,596	$ 162,015	$ 27,419		$ 1,388,323	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Business	Lexus	1997	$ 25,000	$ 373	$ 1,775	$ 1,402	5	$ 2,727	42
43										43
44										44
45										45
46	TOTALS			$ 25,000	$ 373	$ 1,775	$ 1,402		$ 2,727	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 13,180,573	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 402,300	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 653,700	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 251,400	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,795,793	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Excess Cost - Lexus	$ 95,104	$ 1,402	$ 10,258	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 95,104	$ 1,402	$ 10,258	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

HALSTED TERRACE NURSING CENTER, INC.
00020842
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Halsted Terrace Nursing Center	658,325	88,279	65,579	(22,700)	274,978
Halsted Associates	806,360	0	80,636	80,636	505,421
Itex	128,674	15,680	12,839	(2,841)	62,610
TOTALS	1,593,359	103,959	159,054	55,095	843,009
LINE 29: CURRENT YEAR					
Halsted Terrace Nursing Center	32,453	22,390	2,230	(20,160)	(16,251)
Halsted Associates					
Itex	5,101	1,020	501	(519)	501
TOTALS	37,554	23,410	2,731	(20,679)	(15,750)
LINE 30: FULLY DEPRECIATED					
Halsted Terrace Nursing Center	553,470	7,227	230	(6,997)	553,470
Halsted Associates					
Itex	7,594				7,594
TOTALS	561,064	7,227	230	(6,997)	561,064
TOTALS (Should Tie to Totals on Page 13)					
Halsted Terrace Nursing Center	1,244,248	117,896	68,039	(49,857)	812,197
Halsted Associates	806,360		80,636	80,636	505,421
Itex	141,369	16,700	13,340	(3,360)	70,705
TOTALS	2,191,977	134,596	162,015	27,419	1,388,323

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Public Storage				2,236			5
6								6
7	TOTAL				$ 2,236 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 19,686 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1998 Volvo	$ 659.00	$ 7,908	17
18					18
19					19
20					20
21	TOTAL		$ 659.00	$ 7,908	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 59,352	$		$ 59,352	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			22,996			22,996	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			106,533			106,533	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				88,542		88,542	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						42,050		42,050	13
14	TOTAL			$		$ 188,881	$ 130,592		$ 319,473	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	20,239
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	1,508
5	Lab/X-ray	3,293
6	Air Fluidized Beds	17,010
7		
8		
9		
10		
		42,050

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 154,169	$ 155,162	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,471,074	2,471,074	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	191,775	202,164	7
8	Accounts Receivable (owners or related parties)	532,182	1,555,206	8
9	Other(specify): See supplemental schedule	3,233	566,548	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,352,433	$ 4,950,154	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		855,000	13
14	Buildings, at Historical Cost		7,998,898	14
15	Leasehold Improvements, at Historical Cos	1,250,506	1,250,506	15
16	Equipment, at Historical Cost	1,563,563	2,504,101	16
17	Accumulated Depreciation (book methods)	(1,671,909)	(3,991,627)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		284,441	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	403,848	403,848	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,546,008	$ 9,305,167	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,898,441	$ 14,255,321	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,442,683	$ 1,450,683	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	160,413	160,413	28
29	Short-Term Notes Payable	2,392,383	2,392,383	29
30	Accrued Salaries Payable	179,408	179,408	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,445	35,573	31
32	Accrued Real Estate Taxes(Sch.IX-B)		297,851	32
33	Accrued Interest Payable	15,452	67,290	33
34	Deferred Compensation	108,350	108,350	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,048,846	2,048,846	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,379,980	$ 6,740,797	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	74,813	74,813	39
40	Mortgage Payable		8,294,129	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 74,813	$ 8,368,942	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,454,793	$ 15,109,739	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,556,352)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,898,441	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. **#** 00020842 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		
Employee Loans	2,578	2,578
Reimbursement Due	615	615
Credit Union	40	40
Real Estate Tax and Insurance Escrow		232,106
Replacement Reserve		313,721
Repairs Reserve		17,488
	3,233	566,548

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Void Exchange	945	945
Intercompany Exchange	1,023,024	1,023,024
Wage Assignments	502	502
Due to Glenview Terrace	138,466	138,466
Due to Public Aid	885,135	885,135
Short Term Loan Exchange	774	774
	2,048,846	2,048,846

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		
Cash Surrender Value-Life Insurance	403,848	403,848
	403,848	403,848

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,673,166)	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,673,166)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	116,814	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 116,814	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,556,352)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	HALSTED TERRACE NURSING CEN #	00020842	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(1,673,166)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(1,673,166)
Equity(Deficit) from Page 17 Col 1		(1,556,352)
Related Party		
Equity(Deficit)	701934	
Income	0	
		701,934
Combined Equity - End of Year		(854,418)

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,586,042	1
2	Discounts and Allowances for all Levels	(733,178)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,852,864	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	717,812	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 717,812	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	582	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	200,604	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,671	19
20	Radiology and X-Ray		20
21	Other Medical Services	89,361	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 332,218	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,359	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,359	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	7,715	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,715	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,942,968	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,597,501	31
32	Health Care	3,749,876	32
33	General Administration	3,183,653	33
	B. Capital Expense		
34	Ownership	1,760,343	34
	C. Ancillary Expense		
35	Special Cost Centers	370,081	35
36	Provider Participation Fee	164,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,826,154	40
41	**Income before Income Taxes (line 30 minus line 40)****	116,814	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 116,814	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HALSTED TERRACE NURSING C # 00020842 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	40
2	Board of Elections	200
3	Reimbursed auto expense - J. Miller-Johnson	2,990
4	Reimbursed auto expense - C. Miree	1,779
5	Reimbursed auto expense - R. Kenard	854
6	Telephone Commission	423
7	Officers Life Insurance	1,429
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	7,715

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,987	2,091	$ 67,523	$ 32.29	1
2	Assistant Director of Nursing	1,947	2,091	50,001	23.91	2
3	Registered Nurses	23,479	27,374	567,679	20.74	3
4	Licensed Practical Nurses	57,037	66,469	1,077,290	16.21	4
5	Nurse Aides & Orderlies	139,472	153,985	1,191,725	7.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	156	156	7,031	45.07	7
8	Rehab/Therapy Aides	10,728	12,421	123,354	9.93	8
9	Activity Director	835	1,164	14,067	12.09	9
10	Activity Assistants	23,453	25,459	187,561	7.37	10
11	Social Service Workers	7,424	8,278	93,412	11.28	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,478	26,744	10.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,944	37,713	242,370	6.43	15
16	Dishwashers					16
17	Maintenance Workers	5,402	6,127	70,547	11.51	17
18	Housekeepers	41,095	44,028	300,446	6.82	18
19	Laundry	11,733	12,832	74,812	5.83	19
20	Administrator	1,667	1,961	85,016	43.35	20
21	Assistant Administrator					21
22	Other Administrative	2,546	2,754	147,730	53.64	22
23	Office Manager	1,943	2,228	37,857	16.99	23
24	Clerical	17,549	19,338	224,874	11.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,862	2,014	26,161	12.99	31
32	Other Health Care(specify)					32
33	Other(specify)	1,960	2,080	49,679	23.88	33
34	TOTAL (lines 1 - 33)	389,248	433,041	$ 4,665,879 *	$ 10.77	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	290	$ 11,452	1-3	35
36	Medical Director	Monthly	30,600	9-3	36
37	Medical Records Consultant	Monthly	4,107	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,609	10-3	39
40	Physical Therapy Consultant	122	6,113	10a-3	40
41	Occupational Therapy Consultant	102	5,088	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	64	3,212	10a-3	43
44	Activity Consultant	50	1,984	11-3	44
45	Social Service Consultant	70	3,996	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	698	$ 73,161		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	1,960	2,080	$ 49,679	$ 23.88
	1,960	2,080	$ 49,679	$ 23.88

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Randi Kennard (01/01-2/21/00)	Administrator	0	$ 29,264
Joelynn Miller-Johnson (4/17-12/31/00)	Administrator	0	55,752
Mark Hollander (2/22/00-4/16/00)	Administrative	0	147,730
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 232,746

B. Administrative - Other

Description	Amount
Administrative Consultant - See Attached	$ 5,200
Management Fees - See Attached	575,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 580,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 35,327
F. Berkovits & Assoc.	Legal	5,075
Stone, McGuire & Benjamin	Legal	10,328
Harris, Kessler & Goldstein	Legal	4,044
See Attached	Accounting Fees	321,886
AK Care	Bookkeeping Admin Services	392,400
Carepath	Home Office	62,311
LTC Solutions	Computer Support	2,850
Power Software	Computer Support	8,647
Horizon Health	Computer Support	1,930
Personnel Planners	Unemployment Consultant	1,727
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 846,525

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,562
Unemployment Compensation Insurance	82,310
FICA Taxes	350,937
Employee Health Insurance	146,616
Employee Meals	28,072
Illinois Municipal Retirement Fund (IMRF)*	
Head Tax	8,986
Other Employee Benefits	1,824
Retirement Plan	38,200
Christmas Expense	13,265
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,772

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,000
Health Care Worker Background Check	7,852
(Indicate # of checks performed 750)	
Yellow Page Advertising	5,763
Classified Advertising	39,646
Advertising	9,226
Dues & Subscriptions	11,293
Franchise Tax/Licenses	1,467
Allocation from Carepath & Itex	3,527
Less: Public Relations Expense	( )
Non-allowable advertising	(9,225)
Yellow page advertising	(5,763)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,786

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,360
Less: Out of State Travel	(491)
Allocation - Itex	1,495
Allocation - Carepath	47
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,411

**See instructions.

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HALSTED TERRACE NURSING CENTER, INC. # 00020842 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council for Long Term Care $10,558**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **96,170** Line **10-3**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **164,700**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **28,072** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw